

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155557</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>10/18/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MILLER'S MERRY MANOR</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>1651 N CAMPBELL ST</b> <b>INDIANAPOLIS, IN 46218</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00212154 and IN00211621.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00205931 and IN00210874.</p> <p>Complaint IN00212154 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00211621 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00205931 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00210874 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 11, 12, 13, 14, 17, and 18, 2016.</p> <p>Facility number: 000500 Provider number: 155557 AIM number: 100266220</p> <p>Census bed type: SNF: 14 SNF/NF: 46 Total: 60</p> <p>Census payor type: Medicare: 18 Medicaid: 39 Other: 3</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Total: 60  These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.  Quaity review completed by 30576 on October 20, 2016	F 000			